STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		15G238	B. WING		02/21/2014	
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
				ILEY RD		
REM OC	CAZIO LLC		NEW C	CASTLE, IN 47362		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	•	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
W000000						
			W000000			
	This visit was for a fundamental		W 000000			
	recertification a	nd state licensure survey.				
	D + CC	F.1 10.10.20				
	_	: February 18, 19, 20,				
	and 21, 2014.					
	T 11. 1	000761				
	Facility number					
	Provider number: 15G238					
	AIM number: 100234630					
	_					
	Surveyor:					
	Susan Reichert,	QIDP				
	TI C 11 : C	1 116 : : 1				
	_	ederal deficiencies also				
		lings in accordance with				
	460 IAC 9.	1 - 10/0/141 - D. d.				
	Shackelford, QIDP	mpleted 3/3/14 by Ruth				
	Shackehord, QIDF	•				
W000148	483.420(c)(6)	ONI WITH OLIENTS				
	PARENTS &	ON WITH CLIENTS,				
		notify promptly the client's				
		an of any significant				
		nges in the client's condition				
		abuse, or unauthorized				
		review and interview	W000148	The facility must notify prompt	tly 03/21/2014	
			1,000140	the client's parents or guardia		
	•	·		any significant incidents, or		
		u to notify regaily		changes in the client's condition	on	
	including, but not accident, death, a absence. Based on record for 6 of 8 report	Inges in the client's condition Ilimited to, serious illness, abuse, or unauthorized I review and interview able incidents reviewed, d to notify legally	W000148		n of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		1 1			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00			COMPLETED	
		15G238	B. WIN			02/21/2014	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ILEY RD		
DEM OC	CAZIO LLC				ASTLE, IN 47362		
					AGTEE, IIV 47 302		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	authorized repre	sentatives of incidents			including, but not limited to,		
	of use of restrain	nt for 1 of 4 sampled			serious illness, accident, death		
	clients (client #4	and incidents of			abuse, or unauthorized absen-	ce.	
	*	ion for 1 of 4 sampled			What corrective action w	ill	
) and 1 additional client			be accomplished?	""	
	`) and I additional ellent			The program director wi	II	
	(client #7).				be trained on notifying guardia		
					parents, and/or health care		
	Findings include	: :			representatives of any significa	ant	
					incidents or changes in the		
	The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on				client's condition on 3/21/14.		
					2. How will we identify othe		
	_	M. The review indicated			residents having the potential be affected by the same defici		
	the following BDI	DS reports:			practice and what corrective	CIIL	
					action will be taken?		
	-A BDDS report of	lated 6/4/13 indicated			· All residents have the		
	_	n for treatment of a bite			potential to be affected by the		
		l peer at workshop. The			same deficient practice		
	-	e a guardian was contacted			 The program director wi 		
	was marked N/A	_			be trained on notifying guardia	ins,	
	was marked 17/A	(non-applicable).			parents, and/or health care		
	A DDDC remark a	loted 7/22/12 indicated			representatives of any signification	ant	
	_	lated 7/23/13 indicated			incidents or changes in the		
	_	thed by unidentified client			client's condition on 3/21/14.		
	_	nark. The section to			3. What measures will be p	ut	
	_	n was contacted was			into place or what systemic		
	marked N/A (non-	-applicable)			changes will be made to ensur	re	
					that the deficient practice does		
	_	lated 7/26/13 indicated			not recur:		
		by a peer leaving a red			· The program director wi		
		to indicate a guardian			be trained on notifying guardia	ins,	
	was contacted was	s marked N/A			parents, and/or health care		
	(non-applicable)				representatives of any signification	ant	
					incidents or changes in the client's condition on 3/21/14		
	-A BDDS report of	lated 9/4/13 indicated			Cheft S condition on 3/21/14		
	_	oowling alley during a			4. How will the corrective		
		event, became upset and			action be monitored to ensure	the	
		,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		15G238	B. WING		02/21/2014		
				ADDRESS, CITY, STATE, ZIP CODE	l .		
NAME OF F	PROVIDER OR SUPPLIE	R		RILEY RD			
REM OC	CAZIO LLC		NEW CASTLE, IN 47362				
		CT A TEN CENTE OF DEPUGENATION		,	(7/5)		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION		
TAG	` `	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE		
TAG			TAG	deficient practice will not recu			
	**	nder called police and		The area director will	·		
		physically aggressive.		monitor the BDDS reports			
		lient #4 to prevent police		submitted by the program			
	-	him. The section to		director.			
	_	n was contacted was					
	marked N/A (non	-applicable).		5. What is the date by which	:h		
				the systemic changes will be			
		l was reviewed on 2/21/14		completed?			
	at 11:05 AM. The	e record indicated client #1		March 23rd, 2014			
	had a guardian.						
	Client #4's record was reviewed on 2/21/14						
	at 10:40 AM. The	e record indicated client #4					
	had a health care	representative.					
	The Area Directo	r was interviewed on					
	2/21/14 at 11:25	AM. He indicated there					
	was no document	ed evidence client #1's					
	guardian or client	t #4's health care					
	representative we	ere notified of the					
	incidents.						
	9-3-2(a)						
W000154	483.420(d)(3)	ENT OF OUENTO					
		ENT OF CLIENTS have evidence that all					
	alleged violations						
	investigated.	a.o alorouginy					
	,		W000154	The facility must have evidend	03/23/2014		
	Based on record :	review and interview for 1		that all alleged violations are	03/23/2011		
		nts (client #4), the facility		thoroughly investigated			
	•	te a thorough investigation		What corrective action w	vill		
	1	nts reviewed of physically		be accomplished?			
	into i oi 4 incide	ins reviewed of physically	1	· The program director w	III		

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Event ID: Y31R11

Facility ID: 000761

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		15G238	1			02/21/2014	
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
DEMAGO	04710110				LEY RD		
REW OC	CAZIO LLC			NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	aggressive behavi	or.			be re-trained on completing ar	1	
					investigation on 3/21/14.		
	Findings include:				How will we identify othe		
					residents having the potential		
	The facility's repo	orts to the Bureau of			be affected by the same defici	ent	
		isabilities Services			practice and what corrective action will be taken?		
	<u> </u>	iewed on 2/19/14 at 4:45			All residents have the		
	PM and included				potential to be affected by the		
	1 IVI and included	me ronowing.			same deficient practice		
	A RDDS report de	ated 9/4/13 indicated			The program director wi	II .	
		agitated", and began to			be re-trained on completing a		
					thorough investigation on 3/21	/14.	
	hit the wall while at a Special Olympic						
		vas asked if he wanted to			What measures will be p	ut	
	-	n down and when he was			in place or what systemic		
		nis clothes. A staff person			changes will be made to ensur		
	_	o put his clothes back on.			that the deficient practice does	}	
	1 -	d the police and when the			not recur? The program director wi		
	police arrived clie	ent #4 began to become			be re-trained on completing a	"	
	"agitated" and beg	gan to disrobe again.			thorough investigation		
	Police asked clien	t #4 to stop disrobing, and			4. How will the corrective		
	he became physic	ally aggressive to staff.			action be monitored to ensure	the	
	Officers "grabbed	" client #4 and client #4			deficient practice will not recur	?	
	attempted to hit st	aff. The officer informed			 The program director wi 		
	staff if client #4 d	idn't "calm down" he			review random investigations t	ю.	
	would be arrested	for battery. Staff placed			ensure thoroughness		
		ysical hold for 3 minutes					
	_	d staff to release him.			5. What is the date by whic	n	
		n placed in handcuffs and			the systemic changes will be completed?		
		in the police car for			· March 23rd, 2014		
		o charges were filed and			Waron 2014, 2014		
		injured in the incident.					
		indicated staff were					
		4's BSP (Behavior					
	Support Plan) during the incident. "His plan						
		he use of restraint and per					
		aff who utilized the					
	restraint was susp	ended pending an					

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CO			JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		15G238	B. WING			02/21/	2014
			D. WIIW		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				LEY RD		
DEM OC	CAZIO LLC				ASTLE, IN 47362		
	CAZIO LLO			INLVV C/	ASTEE, IN 47302		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	investigation."						
	dated 9/4/13 indic. The investigation statement from cli	ent #4. was interviewed on and indicated the ld have included a					
W000159	PROFESSIONAL Each client's activ be integrated, coo a qualified mental Based on record for 4 of 4 sample #3 and #4) the Q Intellectual Disal failed to ensure of Individual Support when criteria wa review and inclu assessments in the	bilities Professional) objectives included in ort Plans were revised s met, and failed to	W00	00159	Each client's active treatment program must be integrated, coordinated and monitored by qualified mental retardation professional. 1. What corrective action w be accomplished? The program director wibe trained on revising goals where the criteria for completion has been met. The program director wibe trained on gaining the vocational assessments or progress from workshop	ill II	03/23/2014

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Event ID: Y31R11

Facility ID: 000761

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		15G238	B. WIN			02/21/2	2014
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8			ILEY RD		
REM OC	CAZIO LLC				ASTLE, IN 47362		
					1		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PROFILE OR PROTING A CTION SHOULD BE			(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	·		DATE
	Findings include	:			 A communication board be provided for client #7. 	WIII	
					Client #3's ISP will be		
	1. Client #1's rec	cord was reviewed on			updated with an objective to		
	2/21/14 at 11:05 AM. An ISP				address his needs in tooth		
	(Individual Supp	oort Plan) dated			brushing.		
	10/24/13 included objectives to brush						
		n the treadmill, save			2. How will we identify othe		
	money for purchases, and to obtain his medication and water during medication administration. Client #1's record indicated he had met the criteria				residents having the potential be affected by the same defici		
					practice and what corrective	CIII	
					action will be taken?		
					· All residents have the		
					potential to be affected by the		
		0% accuracy. There was			same deficient practice		
		ne record of a revision			The program director wi	ill	
	of client #1's obj	ectives when he met			be trained on revising goals	on	
	criteria.				where the criteria for completion has been met.	UII	
					The program director wi	ill	
	Client #2's recor	d was reviewed on			be trained on gaining the		
	2/21/14 at 11:45	AM. Client #2's ISP			vocational assessments or		
		ncluded objectives to			progress at workshop		
	state guidelines	·			2 What was sures will be m		
	_	tion, identify bills, use a			What measures will be p into place or what systemic	out	
					changes will be made to ensur	re	
		sugar free dessert,			that the deficient practice does		
		d symptoms of low			not recur?		
	-	and throw away his			The program director w	ill	
	_ ^	n when cleaning his			be trained on revising goals		
		#2's record indicated he			where the criteria for completion has been met.	on	
	had met the crite	eria established at 100%			The program director wi	ill	
	accuracy. There	was no evidence in the			be trained on gaining the		
	record of a revis	ion of client #2's			vocational assessments or		
	objectives when	he met criteria.			progress at workshop		
	Client #3's recor	d was reviewed on			How will the corrective action be monitored to ensure	tho	
		AM. Client #3's ISP			deficient practice will not recur		
					The area director will	•	
	dated 8/29/13 in	dicated objectives to			The area director will		

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	OF CORRECTION IDENTIFICATION NUMBER: 15G238	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/21/2014			
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 1803 RILEY RD NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE			
	exercise on the treadmill for 30 minutes, display correct sign when asked, obtain medication and a glass of water for medication administration, identify and count bills, and brush his teeth. The record indicated he had met the criteria established at 100% accuracy. There was no evidence of a revision of client #3's objectives when he met criteria. Client #4's record was reviewed on 2/21/14 at 10:40 AM. An Individual Support Plan dated 8/9/13 indicated objectives to independently talk to a person on the phone, save for purchases, gather items to take medications, make dessert. The record indicated he had met the criteria established at 100% accuracy. There was no evidence of a revision of client #4's objectives when he met criteria. The Area Director and Program Director were interviewed on 2/21/14 at 11:25 AM and indicated the clients objectives should have been revised when met. 2. Client #1's record at the workshop was reviewed on 2/19/14 at 10:55 AM. A vocational assessment dated 10/24/13 indicated client #1 was independent in vocational skills with the exception of obtains more work as needed, adapts to changes in job routine in which he		review goal documentation on least a quarterly basis The area director will review annual ISPs for vocation assessments 5. What is the date by which the systemic changes will be completed? March 23rd 2014	onal			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE (COMPL		
		15G238	A. BUI B. WIN	LDING		02/21/	
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				LEY RD		
REM OC	CAZIO LLC			NEW C	ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		ompts, and checks and		IAG			DATE
	-	rk in which he needed					
		An Annual Program					
		24/13 indicated client					
	-	maintain production					
	rate of 35%.						
		d at the facility was					
		1/14 at 11:05 AM.					
		idence client #1's QIDP					
	(Qualified Intellectual Disabilities						
	1	d reviewed client #1's					
		sment or progress at					
	•	record. There was no					
		vocational assessment in					
	client #1's facilit	y record.					
	Client #2's record	d at the workshop was					
		9/14 at 10:56 AM. A					
	vocational assess	sment dated 9/12/13					
	indicated client #	[‡] 2 was independent in					
	following a sche	dule, obtains work,					
	follows work rul	es, follows instructions,					
	asks for assistant	ce when needed, works					
	cooperatively wi						
		l interaction with					
		quate stamina to meet					
		He required verbal					
		to changes in job					
	•	ansitions smoothly					
	from task to task						
		rk. An Annual Program					
	had an objective	2/13 indicated client #2					
	nau an objective	to manitam a					

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G238		A. BUILD		NSTRUCTION 00	(X3) DATE : COMPL 02/21/	ETED	
NAME OF F	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE	02/21/	2017
REM OC	CAZIO LLC				ASTLE, IN 47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
	production rate of	ıf 5%.					
	reviewed on 2/21 There was no evil had reviewed clicassessment or prother record. There vocational assess facility record. Client #3's record reviewed on 2/19 vocational assess indicated client # were not assessed. Report dated 7/1 had been termina on 1/13/13 and hexercise for 5 mic communicate with than 2 verbal protection. Client #3's record reviewed on 2/21. There was no evil had reviewed clicassessment or prother record. There	nutes and verbally th staff with no more					
		d at the workshop was 0/14 at 11:58 AM. A					

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	00	(X3) DATE SURVEY COMPLETED			
I I I I I I I I I I I I I I I I I I I	15G238	A. BUILDING		02/21/2014			
	1.5540	B. WING	ADDRESS, CITY, STATE, ZIP CODE	1			
NAME OF I	PROVIDER OR SUPPLIER	1803 RILEY RD					
REM OC	CAZIO LLC	NEW CASTLE, IN 47362					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE			
TAG	vocational assessment dated 4/23/13	IAG	DEI ICIENCI)	DATE			
	indicated client #4 was independent in						
	adapts to changes in job routine, follows						
	work rules/procedures, follows						
	instructions, asks for assistance when						
	needed, and required verbal prompts to						
	follow workshop schedule, obtain more						
	work, makes transitions smoothly from						
	task to task, works cooperatively with						
	co-workers, adequate stamina to meet						
	work demands, ability to stay on tasks,						
	and ability to thoroughly complete work.						
	An Annual Program Report dated						
	4/19/13 indicated an objective to						
	maintain a production rate of 4.5%.						
	Client #4's record at the facility was						
	reviewed on 2/21/14 at 10:25 AM.						
	There was no evidence client #4's QIDP						
	had reviewed client #4's vocational						
	assessment or progress at workshop in						
	the record. There was no evidence of the						
	vocational assessment in client #4's						
	facility record.						
	The Area Director was interviewed on						
	2/21/14 at 11:25 AM and indicated there						
	was no evidence the QIDP had reviewed						
	clients #1, #2, #3, and #4's vocational						
	assessments or progress at workshop. He						
	indicated the assessments should be in						
	the clients' facility records.						
	9-3-3(a)						
	γ-3-3(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLI	ETED
		15G238	B. WIN			02/21/	2014
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1803 RILEY RD NEW CASTLE, IN 47362				
(X4) ID	SUMMARY S	RY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
W000255	The individual progreviewed at least to retardation profess necessary, including situations in which successfully compobjectives identified program plan. Based on record the facility failed when achieved for (clients #1, #2, #4) Findings include 1. Client #1's rece 2/21/14 at 11:05 (Individual Supp 10/24/13 include his teeth, walk on money for purchamedication and was administration. Condicated he had established at 10 no evidence in the	leted an objective or d in the individual review and interview, to revise objectives or 4 of 4 sampled clients 3 and #4). cord was reviewed on AM. An ISP ort Plan) dated d objectives to brush or the treadmill, save cases, and to obtain his evater during medication client #1's record	W0	00255	The individual program plan mbe reviewed at least by the qualified mental retardation professional and revised as necessary. Including but not limited to situations in which the client has successfully comple an objective or objectives identified in the individual program plan. 1. What corrective action was be accomplished? The program director wis be re-trained on program monitoring and change on 3/21/14. The goals will be reviewed/revised on a monthly basis. 2. How will we identify other residents having the potential be affected by the same defici practice and what corrective action will be taken?	ne ted vill iiii	03/23/2014

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	_C 00		COMPLETED	
		15G238	B. WIN			02/21/	2014	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF	PROVIDER OR SUPPLIEF	8			ILEY RD			
REM OC	CAZIO LLC				ASTLE, IN 47362			
(X4) ID	SUMMARY S	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	S PLAN OF CORRECTION		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	2/21/14 at 11:45 dated 12/13/13 is state guidelines a pressure medical napkin, make a sidentify signs and blood pressure, a disposable spoor lunchbox. Clienthad met the critical accuracy. There record of a revision objectives when 3. Client#3's recorded at 10:25 dated 8/29/13 in exercise on the transfer display correct signal medication and a medication admit count bills, and brecord indicated established at 10 no evidence of a objectives when 4. Client#4's recorded at 10:40 Support Plan data objectives to indicated the stablished at 10 support Plan data objectives to indicated the stablished at 10 support Plan data objectives to indicated the stablished at 10 support Plan data objectives to indicated the stablished at 10 support Plan data objectives to indicated the stablished at 10 support Plan data objectives to indicated the stablished at 10 support Plan data objectives to indicated the stablished at 10 support Plan data objectives to indicated the stablished at 10 support Plan data objectives to indicated the stablished at 10 support Plan data objectives to indicated the stablished at 10 support Plan data objectives to indicated the stablished at 10 support Plan data objectives to indicated the stablished at 10 support Plan data objectives to indicated the stablished at 10 support Plan data objectives to indicated the stablished at 10 support Plan data objectives to indicate the stablished at 10 support Plan data objectives to indicate the stablished at 10 support Plan data objectives to indicate the stablished at 10 support Plan data objectives to indicate the stablished at 10 support Plan data objectives the sta	tion, identify bills, use a sugar free dessert, d symptoms of low and throw away his a when cleaning his a #2's record indicated he eria established at 100% awas no evidence in the ion of client #2's he met criteria. Ford was reviewed on AM. Client #3's ISP dicated objectives to readmill for 30 minutes, ign when asked, obtain a glass of water for inistration, identify and brush his teeth. The he had met the criteria 10% accuracy. There was revision of client #3's			All residents have the potential to be affected by the same deficient practice The program director w be re-trained on program monitoring and change on 3/21/14. The goals will be reviewed/revised on a monthly basis. 3. What measures will be pinto place or what systemic changes will be made to ensure that the deficient practice does not recur? The program director w be re-trained on program monitoring and change The goals will be reviewed/revised on a monthly basis The area director will review the goals at least quart to monitor for appropriate review/revision 4. How will the corrective action be monitored to ensure deficient practice will not recur. The program director w review/revise the goals month The area director will review the goals at least quart to monitor for appropriate review/revise the goals month The area director will review the goals at least quart to monitor for appropriate review/revise the goals will be completed? March 23rd, 2014	/ out re s ill / erly the ?? ill ly erly		

i '		X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING	COMPLETED	
15G238		B. WING		02/21/2014	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	
				ILEY RD	
REM OC	CAZIO LLC		NEW C	ASTLE, IN 47362	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIATE	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	_	nke medications, make			
		ord indicated he had met			
	the criteria estab				
	=	was no evidence of a			
		#4's objectives when			
	he met criteria.				
	The Area Director and Program Director				
		1 on 2/21/14 at 11:25			
		d the clients' objectives			
	should have beer	n revised when met.			
	9-3-4(a)				
W000312	483.450(e)(2)				
DRUG USAGE		ntral of inappropriate			
	Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan				
		ecifically towards the			
	reduction of and eventual elimination of the				
	behaviors for which	h the drugs are employed.	11/000212	Drugs used for control of	02/22/2014
	D 1 1		W000312	inappropriate behavior must be	03/23/2014
		eview and interview, the		used only as an integral part o	
	_	eduction for each class of		the client's individual program	
		or the management or		plan that is directed specifically	/
		naviors and/or symptoms		towards the reduction of and eventual elimination of the	
		dicated in 2 of 4 sampled		behaviors for which the drugs	are
	clients (clients #1			employed.	
	prescribed medications for management of				
	their behaviors.			 What corrective action w be accomplished? 	/II
				The program director wi	ıı
				1	l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE S	SURVEY	
AND PLAN OF CORRECTION IDEN		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
15G238		B. WING		02/21/	02/21/2014		
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ILEY RD		
DEM OC	CA7IO I I C						
REM OCCAZIO LLC				NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	F	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	Findings include:				be trained on including specific		
	C				criteria for a medication reduct	ion	
	1 Client #1's reco	rd was reviewed on			in the BSP as well as the need	for	
		AM. A BSP (Behavior		the BSP to clearly state which			
		*			medication(s) is targeted for	· · · · · ·	
		ed 10/24/13 indicated			which behavior on 3/21/14.		
	_	f physical aggression,			· Revisions to client's #1,		
	suicidal statement	_			#3, and #4 BSP will be comple		
		oms, delusions, attempt to			to include specific criteria for a		
	harm self, verbal t	hreat/physical gesture to			medication reduction as well a	S	
	harm another, anx	iety. The plan included			clearly stating which		
	the use of Geodon	(anti-psychotic) and			medication(s) is targeted for		
	Paroxetine (antide	pressant). There was no			which behavior		
		medication was targeted			How will we identify othe	r	
		r, or a hierarchy of which			residents having the potential t		
		to be reduced. The plan			be affected by the same deficient		
		*			practice and what corrective	SIIL	
		hat specific criteria			action will be taken?		
	needed to be achieved to the medications to				· All residents have the		
	be considered for	possible reductions.			potential to be affected by the		
					same deficient practice		
	2. Client #4's reco	rd was reviewed on			 The program director wi 	II	
	2/21/14 at 10:40 A	AM. A BSP dated 4/23/13			be trained on including specific		
	indicated target be	haviors of			criteria for a medication reduct	ion	
	non-compliance, SIB (self injurious behavior), property misuse/destruction,				in the BSP as well as clearly		
					stating which medication(s) is		
	/	, and physical aggression.			targeted for which behavior on		
	The plan included the use of Zyprexa (anti-psychotic) and Depakote (mood				3/21/14.		
					· Revisions to all client's		
					BSP will be completed to inclu		
	stabilizer). There was no evidence in the				specific criteria for a medicatio	n	
	record of a plan for which medication was				reduction as well as clearly		
	-	iced or specific criteria			stating which medication(s) is		
		eved to the medications to			targeted for which behavior Area director will monito	r	
	be considered for	possible reductions.			annual ISP to ensure the BSP	1	
					has specific criteria for a		
	The Area Director	and Program Director			medication reduction and all		
		on 2/21/14 at 11:25 AM			medications clearly state which	1	
		plans did not include			medication(s) is targeted for		
	_	r medication reduction of			which behavior.		
	specific criteria io	i modication reduction of					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC		(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	15G238	A. BUILDING	00	02/21/2014
		100200	B. WING	ADDRESS STATE SID SODE	02/2 1/2014
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE ILEY RD	
REM OCCAZIO LLC				ASTLE, IN 47362	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
W000440	were going to be remeasurable medical 9-3-5(a) 483.470(i)(1) EVACUATION DR The facility must helast quarterly for Based on record the facility failed clients (#1, #2 #3 additional clients #8), to ensure an conducted quarter	ellLLS old evacuation drills at each shift of personnel. review and interview, for 4 of 4 sampled and #4), and 4 (clients #5, #6, #7 and evacuation drill was rly for the evening shift 0 PM to 12:00 AM).	W000440	3. What measures will be p into place or what systemic changes will be made to ensure that the deficient practice does not recur? The program director wise retrained on involving the client's guardian/healthcare representative in the developm of the client's BSP on 3/21/14. 4. How will the corrective action be monitored to ensure deficient practice will not recursory. The program director wismonitor the yearly ISP paperw to ensure that the guardian/healthcare representative was involved in yearly implementation of the B. 5. What is the date by whice the systemic changes will be completed? March 23rd, 2014 The facility must hold evacuating drills at least quarterly for each shift personnel 1. What corrective action we be accomplished? The home manager will re-trained on ensuring a fire dron all shifts on 3/21/14. Fire drills will be completed on all shifts as required.	the ? II ork the SP h

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a. building 00			COMPLETED	
15G238		B. WING			02/21/2014	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER					LEY RD	
REM OCCAZIO LLC					ASTLE, IN 47362	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION
TAG				TAG	DEFICIENCY)	DATE
	The facility's eva	cuation drills were			How will we identify othe	
	reviewed on 2/19	9/14 at 5:43 PM. The		residents having the poter		
		the facility had failed to			be affected by the same deficie	ent
		on drills for clients #1,			practice and what corrective	
		·			action will be taken?	
		6, #7 and #8 for 4:00			 All residents have the potential to be affected by the 	
	PM to 12:00 AM	I from $1/6/13$ to $5/3/13$.			same deficient practice	
					· The home manager will	be
	The Home Mana	ger (HM) was			re-trained on ensuring a fire dr	
	interviewed on 2	/19/14 at 1:15 AM. The			is ran on all shits	
		ere were no drills during			· The program director wi	II
		2:00 AM shift from			monitor the drills monthly to	
					ensure they are being ran on a	all
	1/6/13 to 5/3/13.				shifts	
	9-3-7(a)				3. What measures will be p into place or what systemic changes will be made to ensur that the deficient practice does not recur? All residents have the potential to be affected by the same deficient practice The home manager will re-trained on ensuring a fire dr is ran on all shits The program director wi monitor the drills monthly to ensure they are being ran on a shifts How will the corrective action be monitored to ensure deficient practice will not recur The program director wi monitor the drills monthly The area director will monitor the drills at least quart What is the date by which the systemic changes will be	be ill the ? !!

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		IDENTIFICATION NUMBER: 15G238	A. BUILDING B. WING	00	COMPLETED 02/21/2014		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
REM OCCAZIO LLC				ILEY RD ASTLE, IN 47362			
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
				completed? · March 23rd, 2014			

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